The Central African Journal of Medicine

JUNE, 1965

All articles submitted should be typed with double spacing, and abbreviations are to be avoided as far as possible. It is important that the following information should be submitted with each reference quoted: the surname of the author and his initials, the year the article was published, the name of the journal, its volume and the number of the first page of the paper. Photographic illustrations are best on glossy paper and line drawings in black ink. If there is any difficulty in preparing illustrations or drawings, the Editor would be very pleased to arrange for this to be carried out.

Manuscripts forwarded for publication are accepted on the understanding that they are contributed solely to the *Central African Journal of Medicine*.

Communications concerning editorial matter to be addressed to the Editor; those regarding advertising, subscriptions, change of address, etc., to the Assistant Editor, both *Box 2073*, Salisbury, Rhodesia.

The Journal is published monthly. The subscription rate is two guineas *per annum* post free to all parts of the world.

All receipts are expended entirely on the Journal or are devoted to the benefit of the medical and nursing professions.

The Origin of the Human Treponematoses*

Dr. Hackett, probably the greatest living authority on yaws, has given considerable thought to this disease for many years. In his latest report he suggests that there is a close link between yaws, pinta, endemic syphilis and venereal syphilis, on the grounds that they have a similar clinico-pathological picture. He believes that the human treponemes were transferred to man from an animal infection and, as pinta is infectious for much longer than the others, he postulates that this was the first treponematosis of man in about 15000 B.C. and that when the Bering Straight was flooded pinta remained isolated there.

Dr. Hackett then suggests that as long ago as 10000 B.C. the treponema underwent a mutant change in Africa and Asia. The form the disease took here he classifies as yaws. Then thousands of years later another variant arose leading to endemic syphilis, and in 3000 B.C. the last, and perhaps best known as venereal syphilis, first manifested itself in South West Asia. It was not till the late fifteenth century that another mutant change resulted in a more severe variety of venereal syphilis in Europe. It spread throughout the Continent, carrying with it a high death rate. This more severe organism then invaded yaw regions like Africa, where exploration and conquest took place, very quickly replacing the triponema, which had adapted itself to warmer climates.

In the early days of Southern Rhodesia Dr. Andrew Fleming, the Medical Director, frequently referred in his annual reports to the prevalence of yaws in certain localities of the country, notably in the low veld below Fort Victoria. Whether this was yaws or njovera, the endemic syphilis, as it is thought to have been, is of little moment. The point of interest is that many thousands of Africans in their villages were cured of the disease by the energetic action of the Administration of that time, and Southern Rhodesia was probably the first territory in Africa to eradicate the disease through the use of bismuth and arsenic. But, as a result, no immunity to syphilis was conferred on the population originally acclimatised to yaws.

* C. J. Hackett (1961). *Bull. W.H.O.*, 29, 7. On the Origin of the Human Treponematoses (Pinta, Yaws, Endemic Syphilis and Venereal Syphilis).

Tuberculosis Investigations in Rhodesia

BY

JOAN HEFFERNAN

Tuberculosis Research Unit, Medical Research Council, London.

Investigations have recently been undertaken in Rhodesia in collaboration with the British Medical Research Council. Three hospitals are taking part, namely, the Infectious Diseases Hospital, Salisbury, Chinamora hospital and Mpilo hospital, Bulawayo.

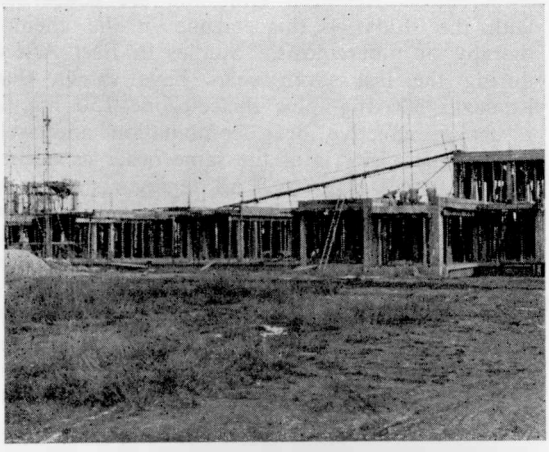
Two of the investigations are co-ordinated in London by the Medical Research Council's Tuberculosis Research Unit and are concerned with the study of thiacetazone in the chemotherapy of tuberculosis. Studies in East Africa during the last seven years have shown that isoniazid 300 mg. plus thiacetazone 150 mg. is a cheap, effective drug combination and well tolerated; toxicity is of the same order as occurs with an isoniazid plus PAS regimen (which is at least five times more expensive than the isoniazid plus thiacetozone regimen). However, as there were conflicting reports from other parts of the world regarding side effects and toxicity from thiacetazone, the Tuberculosis Research Unit organised an investigation in 13 countries throughout the world to study the problem, and one of the centres was in Rhodesia. The results of this investigation are now being analysed, but preliminary assessments suggest that in the majority of cases thiacetazone is an acceptable drug with a small risk of serious toxicity.

The other thiacetazone study in which Rhodesian centres are participating is an investigation of the efficacy of streptomycin with thiacetazone. A current East African study gives preliminary results which suggest that an approximately 85 per cent. success rate at 12 months can be increased to 96 per cent. success by the addition of an initial few weeks of streptomycin to the isoniazid plus thiacetazone regimen. In addition, the results of a few patients found after submission to have isoniazid resistant infections suggest that this regimen may even be effective for these patients. The study in Rhodesia on a large number of patients will therefore provide very important direct information on the efficacy of a streptomycin plus thiacetazone combination.

A third investigation, co-ordinated by an orthopaedic surgeon in Manchester, is under way to study the treatment of active tuberculosis of the spine. Two regimens, isoniazid plus PAS and the same regimen with the addition of streptomycin for three months, are being studied for patients who have no surgery compared with those who have a debridement operation.

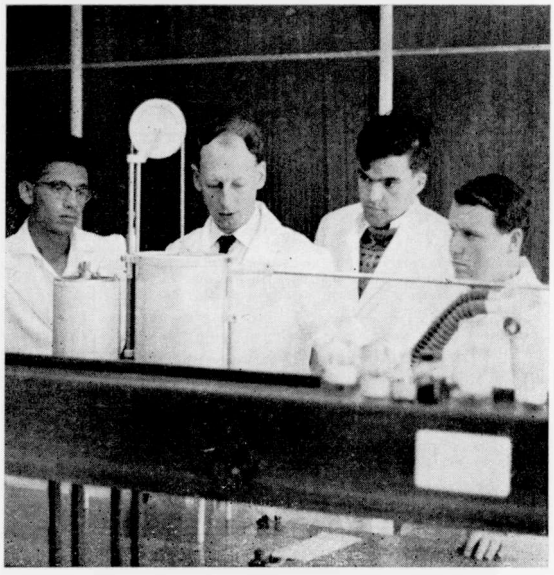
It is hoped to plan further studies in the future with the co-operation of the Rhodesian centres. Investigation of methods of ensuring regularity of drug-taking and continuation of treatment for an adequate period are envisaged and intermittent therapy may be studied in this context.

RHODESIA'S MEDICAL SCHOOL



The Medical School is on its way towards completion. View of the anatomy block (March, 1965).

COURSE IN PHYSIOLOGY BEGINS



Dr. John Nelms, Head of the Department of Physiology, at a practical class. Physiology is taught in the third academic year.

General Medical Council

FUNCTIONS, PROCEDURE AND DISCIPLINARY JURISDICTION (1963)

(Office of the Council: 44 Hallam Street, London, W. 1)

Although the Medical Council of S. Rhodesia has no legal connection with the General Medical Council of the United Kingdom, yet all similar bodies in the Commonwealth look to the parent body as their guide. Its booklet, *Functions, Procedure and Disciplinary Jurisdiction,* is published primarily for the recently qualified in Britain, but it could be read with more than ordinary interest by doctors in Central Africa. Much of what is advised in Britain could apply equally in Rhodesia.

Professional offences include the following:—

(1) Procuring or attempting to procure an abortion or miscarriage.

(2) Adultery or other improper conduct or association with a patient or member of a patient's family.

(3) Disregard of personal responsibilities to patients; gross neglect.

(4) Offences arising out of abuse of alcohol.